UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

IN RE: Acetaminophen – ASD-ADHD
Products Liability Litigation

This Document Relates to: _____

Docket Nos.: 22-md-3043 (DLC)
22-mc-3043 (DLC)

PLAINTIFF FACT SHEET

This Fact Sheet must be completed by each adult plaintiff who has filed a lawsuit related to the Plaintiff Child(ren)'s alleged in utero exposure to Acetaminophen ("APAP") products. Please answer every question to the best of your knowledge. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. "Unknown," as an answer means that you do not have any knowledge regarding the information being requested by the question. You will be able to, and must, supplement your responses if you learn that they are incomplete, incorrect, or you come to possess knowledge for an answer you previously marked as "unknown," in any material respect.

In filling out this form, please use the following definitions: (1) the terms "Plaintiff," "Plaintiffs," "you," and "your" refer to the adult individual(s) referenced in the caption of this Plaintiff Fact Sheet; (2) the term "Birth Mother" refers to the mother of any Plaintiff Child(ren) alleged to have taken APAP products while pregnant with any Plaintiff Child; (3) the term "Plaintiff Child(ren)" refers to the child(ren) allegedly exposed to APAP products in utero who later developed Autism Spectrum Disorder ("ASD") or Attention-Deficit/Hyperactivity Disorder ("ADD" and "ADHD") on whose behalf claims are asserted by Plaintiff; (4) the term "document" means any writing or record of any type that is in your possession or accessible to you (as defined in Section V.A. below), including but not limited to written documents, documents in electronic format, cassettes, videotapes, photographs, charts, computer discs or tapes, and x-rays, drawings, graphs, phone records, non-identical copies, and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form; (5) "APAP product" means any APAP-containing product, including but not limited to pure APAP products as well as combination drugs; (6) "Complaint" means the operative complaint filed in your case, whether original or amended or a subsequent complaint; and (7) the term "health care provider" means, any hospital, clinic, medical center, physician's office, medical or diagnostic laboratory, provider of any and all telemedical services, or other professional medical facility that provides medical, dietary, gynecologic, obstetric, psychiatric, or psychological care or advice, and any pharmacy, weight loss center, x-ray or radiology department, laboratory, physical therapist or physical therapy department, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, nutritionist, dietician, or other persons or entities involved in the evaluation, diagnosis, care, and/or treatment of the Plaintiff Child(ren) and/or the Plaintiff Child(ren)'s birth mother, as referenced or requested in this Fact Sheet.

This Plaintiff Fact Sheet is completed pursuant to the Federal Rules of Civil Procedure governing discovery (or, for state court cases, the governing rules of the state in which the case is pending) and any MDL Discovery Orders as defined in the MDL Court's Coordination Order (DE 382 at ¶ 4).

I. CASE INFORMATION

A. Identification of Person Filling out Plaintiff Fact Sheet

1. Full name of the person completing this form:

2. If you are completing this Plaintiff Fact Sheet in a representative capacity (*e.g.*, on behalf of the Plaintiff Mother, the Plaintiff Child, or any Other Plaintiff), please complete the following: [Include N/A option]

   a. Current address:

   b. Date of Birth (MM/DD/YYYY):

   c. Relationship to the individual you represent:

   d. If you were appointed by a court, state the:

      i. Court:

      ii. Date of Appointment:

B. Information about the Plaintiff Child(ren)

1. Total number of Plaintiff Child(ren) you represent with claims at issue in this suit: [Populate and determine number of tables in Section]

2. With respect to each Plaintiff Child who is asserting claims in this lawsuit, please fill out the following:
   [*Note:* The information filled out in this table will populate the Plaintiff Child specific portions of this fact sheet, below.]

Plaintiff Child No.	**Plaintiff Child Name (First Name and Last Name)**	**Date of Birth** (MM/DD/YYYY)	**Age**	**Claimed Injury**	**Diagnosis confirmed by medical/assessment professional? [Y/N]**	**If yes, Date of Diagnosis**
				[Drop-down: Autism-Spectrum		

				Disorder (ASD); Attention-Deficit/Hyperactivity Disorder (ADHD); Both]		

II. BIRTH MOTHER

A. Birth Mother's Identity and Background Information

1. Is Birth Mother different than adult Plaintiff filling out this PFS? [Y/N]

2. Please provide the following information regarding Birth Mother:

   a. Full name:

   b. Maiden name, or other names used, and dates Birth Mother used those names:

Birth Mother's Name(s)	Date(s) Used (MM/YYYY to MM/YYYY)

   c. Date of Birth (MM/DD/YYYY):

   d. Place of Birth (City, State, Zip Code, Country):

   e. Do you have a Social Security Number? [Y/N]

      i. If "Yes," please provide it (XXX-XX-XXXX):

      ii. If "No," please provide your Driver's License Number or State Identification Number, and the issuing state:

   f. Identify each address at which the Plaintiff/Birth Mother resided while pregnant with each Plaintiff Child with claims asserted in this case, as well as the Birth Mother's current address, and the approximate dates the Birth Mother resided at each.

Address (Street Address, City, State, Zip Code, Country)	Dates of Residence (MM/YYYY to MM/YYYY)

3. Has Birth Mother ever filed another personal injury or product liability lawsuit or claim with respect to ASD, ADHD or any behavioral or neurodevelopmental disorder on behalf of the Plaintiff Child(ren)? [Y/N]

   a. If "Yes," please fill out the table below:

Case Name and Number	Jurisdiction	Date of Filing	Nature of Claim	Injury Claimed	Status	Plaintiffs' Counsel	Which Plaintiff Child

B. <u>Product Identification and Use</u>

1. Do you claim that Birth Mother ingested an APAP product while pregnant with the Plaintiff Child(ren)? [Y/N]

   If "Yes," please fill out the information set forth in the table below with respect to each APAP product you contend that Birth Mother ingested during her pregnancy with the Plaintiff Child(ren). If Birth Mother took more than one APAP product, or took APAP during her pregnancies for multiple Plaintiff Children, you should fill out a separate instance for each by adding an additional product table using the "Additional Product" option below.

   Note: For purposes of providing the product name, it is not sufficient to simply write "Acetaminophen." You must provide as much information as you possess at this time regarding the full product name as reflected on the packaging so that the parties to this litigation are able to identify the product. To the extent you do not know/do not recall the answer to any of the questions listed below, you must indicate that you do not know by answering "unknown." You may not leave any field blank.

Specific product name	
Form (e.g., tablets, capsules, gel caps, extended release)	
Strength (mg)	
Bottle or packaging size (*i.e.*, number of pills)	
Where was the APAP product purchased?	Store name: Street Address: City, State:
When was the APAP product purchased?	[MM/YYYY]
When did Birth Mother take the APAP product? (MM/YYYY to MM/YYYY)	Date: _____ Trimester: [Radio buttons: First, Second, Third] Which Plaintiff Child? _____
Frequency of Use (*e.g.*, times per week)	
Reason for taking the APAP product	

Did Birth Mother consult with a healthcare provider prior to taking the APAP product?	[Y/N] If "Yes," please fill out the following: ☐ OBGYN identified in Section _____. [Include drop-down for OBGYN names as filled out in the form] ☐ OBGYN not identified in Section ___. [Insert field for name, address, phone number and email for OBGYN]

[Include option to generate Additional Product tables.]

C. Birth Mother's Medical Background and Social History

1. Has Birth Mother been diagnosed, tested for, or treated for ASD, ADHD, or any other neurodevelopmental disorder? [Y/N]

   a. If "Yes," please provide the following information for each such condition:

Condition	
Diagnosis Date	
Treatment Date Range	
Name of Treating Healthcare Provider(s)	
Address and Phone Number for Healthcare Provider(s)	

[Include option to insert additional tables as needed for additional conditions]

2. Does Birth Mother have an immediate family history of ASD or ADHD? [Y/N]

   Note: For purposes of this question, "immediate family" includes parents and siblings

   a. If "Yes," please provide the following information:

Name	**Date of Birth**	**Relationship to Plaintiff Child(ren)**	**Diagnosis**

3. Identify the following information for any OB/GYN who examined, treated, or consulted with the Birth Mother for the period covering her pregnancies with Plaintiff Child/Children with claims asserted in this case. In responding, you must include each OB/GYN who examined, treated, or consulted with the Birth Mother during her pregnancy with each Plaintiff Child.

OB/GYN Name	**Location (City, State)**	**Contact Information**	**Time Period of Treatment**	**Treatment for Pregnancy with which Plaintiff**

		(Phone and Email)		Child (if applicable)?
				[Drop-down]

4. Please indicate whether Birth Mother's medical history includes any of the following conditions, diseases, or illnesses, whether in the past or currently. To the extent you check "Yes" to any item in the table below, please provide all corresponding information for that condition, disease, or illness, as requested in the table below.

Condition/Disease/ Illness	Yes/ No	Date/Date Range	Treating Physician(s)	Treating Physician's Address	Treating Physician Phone Number	Treating Physician Email	Medications taken or other treatment received for Condition/ Disease/Illness
Obesity							
Auto-immune diseases (including but not limited to Crohn's disease, Ulcerative Colitis)							
Diagnosis of depression, anxiety, bipolar, or other affective/mood disorders							
Seizures, seizure disorders, or epilepsy							
Diabetes (other than gestational diabetes)							
Hypertension							

5. Please identify whether Birth Mother experienced or was diagnosed with any of the following conditions, illnesses, or occurrences during her pregnancy with the Plaintiff Child(ren). To the extent you check "Yes" to any item in the table below, please provide all corresponding information for that condition, illness or occurrence, as requested in the table below.

Condition/Illness/ Occurrence	**Yes/ No**	**Affected Child**	**Date/ date Range**	**Treating Physician(s)**	**Treating Physician's Address**	**Treating Physician Phone Number**	**Treating Physician Email**	**Medications taken or other treatment received for Condition/ Disease/Occurrence**
Gestational Diabetes								
Diagnosed Infection, including but not limited to rubella or measles, mumps, herpes simplex, Epstein Barr, bacterial infections, influenza, coronavirus, RSV, UTI and/or cytomegalovirus								
Prenatal fever ≥ 100.4 degrees								
Threatened pre-term delivery, pre-term delivery, pre-term rupture of membranes, pre-term contraction or tocolytic therapy								

Abnormal birthing presentation during labor (including but not limited to face, brow, breech, shoulder, and/or forward-facing positions)								
Fetal distress, birth injury, or birth trauma, including but not limited to umbilical cord complications, or asphyxia to newborn shortly before or during birth								
Bleeding or spotting								
Preeclampsia								
Cerclage								
Migraine and/or chronic headaches that was treated with medication								

Surgery during pregnancy								
Gestational hypertension								
A diagnosis of acute anxiety or depression								

6. Has Birth Mother had any pregnancies that did not result in a live birth? [Y/N]

Note: For purposes of answering this question, you only need to disclose miscarriages, still births, or terminations that were medically necessary or performed based on the advice of a medical professional to protect maternal or fetal physical health. Do not disclose elective terminations.

a. If "Yes," please fill out the information in the table below for each such pregnancy.

Date range of pregnancy	**Date pregnancy was concluded**	**Name of the healthcare provider and hospital/facility that treated Birth Mother**	**Reason that the pregnancy did not result in a live birth**
(MM/YYYY – MM/YYYY)			

7. Identify each pharmacy that has dispensed medication to Birth Mother for the period covering her pregnancy/pregnancies with each Plaintiff Child asserting claims in this case. For each pharmacy, please fill out all information requested in the table below.

Pharmacy Name	**Pharmacy Address and Phone Number**	**Name of Medication Dispensed**	**Reason for Medication**	**Date Range Pharmacy Used by Birth Mother**

8. Other than the product(s) identified in Section II.B, above, identify each over-the-counter drug that Birth Mother took during her pregnancy with the Plaintiff Child(ren). For each such drug, please fill out all information requested in the table below.

Name of Drug	**Manufacturer**	**Dose and Frequency of Use**	**Date Range Taken**	**Healthcare Provider that**	**Reason for Use**	**Identification of Relevant**

				Directed Use		Plaintiff Child
						[Drop Down]

9. Identify each supplement, including all vitamins, prenatal vitamins, nutritional supplements, and all herbal and homeopathic medications and remedies, that Birth Mother took during her pregnancy with the Plaintiff Child(ren). For each such supplement, please fill out the information requested in the table below.

Name of Supplement	Manufacturer (if known)	Dose and Frequency of Use	Date Range Taken	Healthcare Provider that Directed Use	Reason for Use	Identification of Relevant Plaintiff Child
						[Drop Down]

10. If the Plaintiff Child(ren) claim(s) ADHD as an injury: Did Birth Mother use any tobacco, in any form, at any time during her pregnancy with the Plaintiff Child(ren), or after, while breastfeeding? [Y/N]

    a. If "Yes," please answer the following:

        i. Type of tobacco:

        ii. Which Plaintiff Child was in *utero* during tobacco use?

        iii. Date on which Birth Mother began using tobacco:

        iv. Date on which Birth Mother ceased using tobacco:

        v. Amount of tobacco used while Plaintiff Child was in *utero*: ____ per day.

        vi. Amount of tobacco used while breastfeeding: ____ per day

11. If the Plaintiff Child(ren) claim(s) ADHD as an injury: Did Birth Mother reside with any individual who smoked tobacco at any time during her pregnancy with the Plaintiff Child(ren), or after, while breastfeeding? [Y/N]

    a. If "Yes," please answer the following:

        i. Name of individual who smoked tobacco:

        ii. Which Plaintiff Child was *in utero* or breastfed during the Birth Mother's second hand exposure to this tobacco use?

iii. Date(s) of residence with individual who smoked tobacco:

12. If the Plaintiff Child(ren) claim(s) ADHD as an injury: Did Birth Mother consume any alcohol, marijuana, or illicit drugs at any time during her pregnancy with the Plaintiff Child(ren), or after, while breastfeeding? [Y/N]

a. If "Yes," please fill out the following table:

Substance	Method of Consumption	Amount Consumed	Approximate Date(s) of Consumption (if known)	Frequency (how often)	During Pregnancy with which Plaintiff Child
					[Drop-down]

13. Does the Birth Mother have any children, other than the Plaintiff Child(ren)? [Y/N]

a. If "Yes", please fill out the table below, including identification of whether any of the children below have been diagnosed with epilepsy, depression, anxiety, bipolar disorder, schizophrenia, or other affective/mood disorders or with any neurodevelopmental, or developmental disorders, including ASD or ADHD, and, if so, please provide the other requested information:

Child Name	
Age	
Diagnosed with epilepsy, depression, anxiety, bipolar disorder, schizophrenia, or other affective/mood disorders, or with any neurodevelopmental, or developmental disorders, including but not limited to ASD or ADHD? [Y/N]	
If yes, identify the diagnosis	

III. BIOLOGICAL FATHER INFORMATION

[*NTD:* There may be cases with multiple biological fathers. The PFS form should have an option for adding additional biological father profiles, and for linking each biological father profile to the relevant Plaintiff Child(ren)]

A. Biological Father's Identity and Background Information

1. Full name:

2. Do you have contact with Biological Father? [Y/N]

3. Do you know the Biological Father's identifying information? [Y/N]

4. Other names used, and dates Biological Father used those names:

Prior Name(s)	Date(s) Used (MM/YYYY to MM/YYYY)

5. Date of Birth (MM/DD/YYYY):

6. Has Biological Father ever filed any other personal injury or product liability lawsuit or claim with respect to ASD, ADHD, or any other behavioral or neurodevelopmental disorder on behalf of the Plaintiff Child(ren)? [Y/N]

    i. If "Yes," please fill out the table below:

Case Name and Number	Jurisdiction	Date of Filing	Nature of Claim	Injury Claimed	Status	Plaintiffs' Counsel	Which Plaintiff Child

B. <u>Biological Father's Medical Background and Social History</u>

1. Has Biological Father been diagnosed, tested for or treated for ASD or ADHD? [Y/N]

    a. If "Yes," please provide the following information for each such condition:

Condition	
Diagnosis Date	
Treatment Date Range	
Name of Treating Healthcare Provider(s)	
Address and Phone Number for Healthcare Provider(s)	

[Include option to insert additional tables as needed for additional conditions]

2. Does Biological Father have an immediate family history of ASD or ADHD? [Y/N]

    Note: For purposes of this question, "immediate family" includes parents and siblings.

    a. If "Yes," please provide the following information:

Name	Date of Birth	Relationship to Plaintiff Child(ren)	Diagnosis

3. Please indicate whether Biological Father's medical history includes any of the following conditions, diseases or illnesses, whether in the past or currently. To the extent you check "Yes" to any item in the table below, please provide all corresponding information for that condition, disease or illness, as requested in the table below.

Condition/Disease/Illness	**Yes**	**No**	**Date of Diagnosis**	**Treating Physician**	**Treating Physician Address**	**Treating Physician Phone & Email**
Depression, anxiety, bipolar, or other affective/mood disorders						
Seizures, seizure disorders, or epilepsy						

4. Does Biological Father have any biological children, other than the Plaintiff Child(ren) or children with Birth Mother? [Y/N]

   a. If "Yes", please fill out the table below, including identification of whether any of the biological Children below have been diagnosed with epilepsy, depression, anxiety, bipolar disorder, schizophrenia, or other affective/mood disorders, or with any neurodevelopmental , neurodevelopmental, or developmental disorders, including ASD or ADHD, and, if so, please provide the other requested information:

Child Name	
Age	
Diagnosed with epilepsy, depression, anxiety, bipolar disorder, schizophrenia, or other affective/mood disorders or with any neurodevelopmental, or with any neurodevelopmental, or developmental disorders, including but not limited to ASD or ADHD? [Y/N]	
If yes, Identify Diagnosis	
Date of Diagnosis	

[Option to add additional tables for additional children]

IV. PLAINTIFF CHILD # ____

[NOTE: Live form to create a new "Plaintiff Child" section for each Plaintiff Child identified in Section I.B.2, above.]

A. Plaintiff Child's Identifying and Background Information

1. Full name:

2. Other names by which Plaintiff Child has been known (including nicknames or aliases, to the extent that name would be used or reflected in the Plaintiff Child's medical records):

3. Date of Birth (MM/DD/YYYY):

4. Approximate number of weeks Birth Mother was pregnant with Plaintiff Child:

5. Place of birth (City, State, Zip Code):

6. Age: [to be auto-populated once DOB is filled out]

7. Gender:

8. SSN:

9. Current address, if different than Birth Mother's current address, and date when Plaintiff Child began living at this address:

10. Identify each prior address at which the Plaintiff Child has resided in the following:

Address (Street Address, City, State, Zip Code, Country)	**Dates of Residence (MM/YYYY to MM/YYYY)**	

11. Current guardian:
[Insert radio buttons: Birth Mother; Biological Father; Other: _____]

B. Plaintiff Child's Claimed Injury

1. Identify the injury or injuries claimed by the Plaintiff Child, and for each such injury, provide all information requested below.
[Radio buttons: Autism Spectrum Disorder (ASD); Attention-Deficit/Hyperactivity Disorder (ADHD).]
[Note: The information below should appear depending on the radio button clicked by Plaintiff.]

   a. If you selected ASD, please provide the following information:

      i. Has the Plaintiff Child been diagnosed with ASD? [Yes/No/Tentative Diagnosis]

      - Note: For purposes of this section, a "tentative diagnosis" is a diagnosis of ASD made by a healthcare professional upon a medical finding that the child meets

the diagnostic criteria for ASD as of the time of the evaluation, but is too young to have a confirmed or final diagnosis of ASD.

ii. Provide the date of diagnosis, if any:

iii. Provide the name, address and phone number of the healthcare provider who diagnosed or tentatively diagnosed the Plaintiff Child.

iv. If the Plaintiff Child has not yet been diagnosed, please explain why:

v. Has any healthcare provider ever determined that the Plaintiff Child does not have ASD? [Y/N]

- If "Yes," please provide the date of any such determination, and the name, address and phone number of the healthcare provider who reached that conclusion.

vi. Describe the symptoms or behaviors that caused the Plaintiff Child's parent or guardian to either seek ASD treatment or diagnosis for Plaintiff Child, or to believe that the Plaintiff Child has ASD:

vii. Provide the date that the Plaintiff Child's Birth Mother, Biological Father, or Guardian first (1) noticed the Plaintiff Child exhibiting symptoms or behaviors causing him or her to believe the Plaintiff Child has ASD; or (2) learned of the Plaintiff Child exhibiting such symptoms or behaviors from another person.

- Date (MM/YYYY): _____

viii. If the Birth Mother, Biological Father, or Guardian first learned of the Plaintiff Child's symptoms or behaviors from another person, please identify that person, and provide the following information for him or her.

☐ Not applicable

☐ If applicable:

- Full Name: _____
- Address: _____
- Phone number (if known): _____
- Relationship to Plaintiff Child: _____

ix. Has the Plaintiff Child undergone any cognitive or behavioral testing or assessments? If yes, please identify any such testing or assessment, and provide the approximate date of the testing or assessment and its results:

x. Provide the following information for any healthcare providers who have treated, consulted, or conducted cognitive or behavioral testing or assessments on the Plaintiff Child with regards to the Plaintiff Child's treatment or evaluation for ASD.

Healthcare Professional Name	Healthcare Provider's Specialty	Address	Contact Information (Phone and Email)	Time Period of Treatment	Reason for Treatment

xi. If known, please identify the Level of Plaintiff Child's ASD, as diagnosed by a medical professional:
[Dropdown: Level 1 ("Requiring support"); Level 2 ("Requiring substantial support"); Level 3 ("Requiring very substantial support."); ("Do not know")]

b. If you selected ADHD, please provide the following information:

i. Has the Plaintiff Child been diagnosed with ADHD? [Y/N]

ii. Provide the date of diagnosis, if any:

iii. Provide the name, address and phone number of the healthcare provider who diagnosed or tentatively diagnosed the Plaintiff Child.

iv. If the Plaintiff Child has not yet been diagnosed, please explain why:

v. Has any healthcare provider ever determined that Plaintiff Child does not have ADHD? [Y/N]

- If "Yes," please provide the date of any such determination, and the name, address and phone number of the healthcare provider who reached that conclusion.

vi. Describe the symptoms or behaviors that caused you to either seek ADHD treatment or diagnosis for Plaintiff Child, or to believe that Plaintiff Child has ADHD:

vii. Provide the date that the Plaintiff Child's Birth Mother, Biological Father, or Guardian first (1) noticed the Plaintiff Child exhibiting symptoms or behaviors causing him or her to believe the Plaintiff Child has ADHD; or (2) learned of the Plaintiff Child exhibiting such symptoms or behaviors from another person.

Date (MM/YYYY): _____

viii. If the Birth Mother, Biological Father, or Guardian first learned of the Plaintiff Child's symptoms or behaviors from another person, please identify that person, and provide the following information for him or her.

☐ Not applicable

☐ If applicable:

- Full Name: _____
- Address: _____
- Phone number (if known): _____
- Relationship to Plaintiff Child: _____

ix. Has the Plaintiff Child undergone any cognitive or behavioral testing or assessments? If yes, please identify any such testing or assessment, and provide the approximate date of the testing or assessment and its results: Provide the following information for any healthcare providers who have treated, consulted, or conducted cognitive or behavioral testing or assessments on the Plaintiff Child with regards to the Plaintiff Child's treatment or evaluation for ADHD.

Healthcare Professional Name	**Healthcare Provider's Specialty**	**Address**	**Contact Information (Phone and Email)**	**Time Period of Treatment**	**Reason for Treatment**

x. What type of ADHD does the Plaintiff Child have, as diagnosed by a medical professional?
[Dropdown: Combined type; Impulsive/hyperactive type; Inattentive and distractible type; Do not know]

2. Has any healthcare provider ever told you the cause or likely cause of Plaintiff Child's ASD or ADHD? [Y/N]

a. If "Yes," provide the following information:

Healthcare Professional Name	**ASD/ADHD/Other**	**Reason Provided**	**Information Provided**

C. Plaintiff Child's Medical History

1. Other than the healthcare providers identified in response to question IV.B.1, above, identify all healthcare providers who have examined, treated, or provided consultation to Plaintiff Child from birth to present and, for each, provide the information set forth in the table below.

Healthcare Professional Name	Healthcare Provider's Specialty	Address	Contact Information (Phone and Email)	Time Period of Treatment	Reason for Treatment

2. Identify each medication that Plaintiff Child has been prescribed for treatment of his/her ASD or ADHD, and for each medication provide the information set forth in the table below.

Medication	Dose	Date/Date Range of Fills	Pharmacy Name	Pharmacy Address	Pharmacy Phone Number	Prescribing Healthcare Professional	Reason for Medication

3. To the extent not identified in response to question IV.B.3, above, identify each pharmacy that has dispensed medication to Plaintiff Child since birth.

Pharmacy Name	Address and Phone Number	Date Range of Fills at Pharmacy

4. Please indicate whether Plaintiff Child's medical history includes any of the following conditions, diseases, or occurrences. To the extent you check "Yes" to any item in the table below, please provide all corresponding information for that condition, disease of illness, as requested in the table below.

Condition/Disease/ Occurrence	Yes/No [Drop-down]	Exact Diagnosis/ Disease/ Occurrence	Date of Diagnosis or Procedure	Treating Physician
Low Birth Weight (under 5.5 lbs)				
Auto-immune diseases (including but not limited to Crohn's disease, Ulcerative Colitis)				

Genetic syndromes (including but not limited to Down syndrome, Fragile X syndrome, Phelan McDermid syndrome, PTEN Hamartoma syndrome, Rett syndrome, Prader-Willi and Angelman)				
Seizures, seizure disorders, or epilepsy				
Communication deficit or delay (*e.g.*, hearing, speech, language)				
Depression, anxiety, bipolar, or other affective/mood disorders				
Neurocognitive, neurodevelopmental or other psychiatric diagnoses (other than ASD and ADHD)				

5. Has Plaintiff's Birth Mother, Biological Father, the Plaintiff Child, or any of Plaintiff Child's biological siblings (if any), undergone microme array or exome sequencing genetic testing? [Y/N]

   a. If "Yes" please fill out the table below.

Name of Person who Underwent Genetic Testing	**Health Care Provider Name**	**Genetic Tests Ordered**	**Reason Genetic Tests Were Ordered**	**Date(s) of Testing**	**Results**

D. <u>Plaintiff Child's Family History</u>

1. To your knowledge, does Plaintiff Child have any biological family members, including grandparents, parents, siblings, aunts, uncles, or cousins, with any of the following genetic syndromes? If yes, please provide the information set forth in the table below.

Genetic Syndrome	Y/N [Drop-down]	Family Member's Name	Family Member's Current Age (Actual or Approximate)	Relationship to Plaintiff Child
Down syndrome				
Fragile X syndrome				
Phelan McDermid syndrome				
PTEN Hamartoma syndrome				
Rett syndrome				
Prader-Willi syndrome				
Angelman syndrome				
Other:_____ *(fill in name)*				

E. <u>Plaintiff Child's Education and Abilities</u>

1. Identify each school or other educational institution Plaintiff Child has attended by filling out all portions of the table below.

Name of School or Institution	City, State	Grade Levels Attended for	Years of Enrollment

2. Has Plaintiff Child been provided with an Individualized Education Program (IEP), 504 plan, or other formal accommodation by any past or present school? [Y/N]

   a. If "Yes," please fill out the table below.

Name of School/Institution	Type of accommodation	Date of approval	Services or Accommodations Provided	Diagnosis/Condition for Which Services or Accommodations were Provided

	[Drop-down: IEP, 504, Other]			

b. If "No," does the Plaintiff Child participate in a formal Early Intervention Program? [Y/N]

Name of School/Institution	Type of accommodation	Date of approval	Services or Accommodations Provided	Diagnosis/Condition for Which Services or Accommodations were Provided
	[Drop-down: IEP, 504, Other]			

c. If you answered "Yes," to either Question 2.a, or 2.b, above, was the Plaintiff Child assessed or evaluated with respect to the creation or approval of his/her IEP, 504, formal accommodation, or enrollment in the Early Intervention Program?

i. If "Yes," identify who evaluated the Plaintiff Child, when, and provide the address and phone number for this individual:

Name of Evaluator(s)	When Evaluation was Performed	Address and Phone Number of Evaluator

d. Other than any assistance identified in response to Section IV.E.1 and IV.E.2, above, does Plaintiff Child require the assistance of a home care aide or other attendant to assist in education or daily activities because of his or her ASD or ADHD? [Y/N]

i. If "Yes," please provide the full name, address phone number, and responsibilities for that person:

Name	Company/Employer	Responsibilities

V. DOCUMENT REQUESTS

A. Records Evidencing Purchase, APAP Use and Alleged Injury

The documents requested in this section are documents that you are required to produce either (a) with your Fact Sheet, or (b) as a supplemental production after you produce your Fact Sheet, if you do not have the documents in your possession at the time you produce your Fact Sheet. For purposes of responding to the questions in this section, documents are "Accessible" if they are (1) in your possession, or (2) accessible via a request directed at the appropriate person and/or entity. For the documents listed in this section, if you do not currently have the documents requested in your possession, you must request the records prior to or no later than 14 days of submitting this Fact Sheet. Once received, you should supplement your records production as promptly as possible.

1. All documents evidencing your purchase, or someone else's purchase on your behalf or on behalf of Birth Mother, of the APAP products identified in Section II.B, above, including receipts, credit card statements, loyalty/rewards records reflecting the purchase of the APAP products, or medical records referencing Birth Mother's APAP use during pregnancy. [Document(s) produced/Document(s) requested, and will be produced upon receipt/Document(s) will be requested in the next fourteen (14) days, and will be produced upon receipt/No such document(s) exist(s)/Document(s) is/are no longer Accessible.]

2. Photographs or copies of any APAP product packaging or bottle reflecting the products identified in Section II.B, above.

   Note: In the event you have the product packaging or bottle, and do not have a photograph or copy of it, please take a photograph of the bottle or packaging (including all aspects of the bottle or packaging, so that the full label and packaging information are legible), or make a copy of the packaging, and produce that with your PFS. Any such bottle or packaging should separately be preserved.

   [Document(s) produced/Plaintiff(s) no longer have the APAP products at issue]

3. Medical records evidencing the Plaintiff Child's final or tentative diagnosis with ASD and/or ADHD.
   [Document(s) produced/Document(s) requested, and will be produced upon receipt/Document(s) will be requested in the next fourteen (14) days, and will be produced upon receipt/No such document(s) exist(s)/Document(s) is/are no longer Accessible.]

4. OB/GYN records for the Birth Mother, covering the period of Birth Mother's pregnancy with the Plaintiff Child(ren) through delivery and post-partum care. [Document(s) produced/Document(s) requested, and will be produced upon receipt/Document(s) will be requested in the next fourteen (14) days, and will be produced upon receipt/No such document(s) exist(s)/Document(s) is/are no longer Accessible.]

5. To the extent any claims are asserted in a representative capacity, other than by a custodial parent, on behalf of any Plaintiff Child(ren) or any "Other" Plaintiff in these proceedings, documentation sufficient to establish the representative's capacity and/or authority to assert any such claims.
[Document(s) produced/Document(s) requested, and will be produced upon receipt/Document(s) will be requested in the next fourteen (14) days, and will be produced upon receipt/No such document(s) exist(s)/Document(s) is/are no longer Accessible.]

B. Other Records

The documents set forth in this section must be produced if they are in your, or your counsel's, custody or possession. In responding to the questions below, please indicate whether you possess the documents identified below and, if you check "Yes," attach a copy of the documents to this Plaintiff Fact Sheet. Nothing in this section precludes Defendants' from requiring these documents, if they are Accessible, at a later point as described in the Court's Order: Plaintiff Fact Sheets (DE ___ at ¶ 5).

1. All non attorney-client privileged documents you reviewed in the preparation of answers to this Plaintiff Fact Sheet.
[Document(s) produced/No such document(s) exist(s)]

2. A copy of all medical records, testing records, treatment records, therapy records, and/or documents from any healthcare provider, counselor, therapist, or social worker who has treated or worked with the Plaintiff Child(ren) for ASD, ADHD, or any other neurodevelopmental disorder referred to in your responses above. (Do not provide duplicate records if these have been provided in response to another question.)
[Document(s) produced/No such document(s) exist(s)/No such document(s) in my possession]

3. Copies of any advertisements or promotions for the APAP products identified in Section II.B upon which Birth Mother claims to have relied in selecting and deciding to take the APAP products identified in Section II.B, above.
[Document(s) produced/No such document(s) exist(s)/No such document(s) in my possession]

6. Copies of any cognitive or behavioral testing or assessments performed in relation to any final or tentative diagnosis of ASD and/or ADHD claimed by Plaintiff Child in Section IV.B, above.
[Document(s) produced/No such document(s) exist(s)/No such document(s) in my possession]

7. Genetic testing, results, and diagnostic records for Birth Mother, Birth Father, the Plaintiff Child(ren) and any siblings of the Plaintiff Child(ren) relating to assessments and testing for ASD, ADHD, or any other neurodevelopmental disorder.
[Document(s) produced/No such document(s) exist(s)/No such document(s) in my possession]

4. A copy of all genetic testing records for the Plaintiff Child(ren), Birth Mother, and/or Biological Father.
[Document(s) produced/No such document(s) exist(s)/No such document(s) in my possession]

5. All documents obtained directly or indirectly from any of the Defendants relating to this case, the claims asserted in this case, or the APAP products at issue in this case. [Document(s) produced/No such document(s) exist(s)]

6. All applications for government assistance, Independent Education Programs, or other services or accommodations applied for by or on behalf of the Plaintiff Child directly related to his/her ASD and/or ADHD, as identified in Section IV.E, above.
[Document(s) produced/No such document(s) exist(s)/No such document(s) in my possession]

7. All documents constituting communications or correspondence between you and any representative of the Defendants.
[Document(s) produced/No such document(s) exist(s)]

8. Copies of all public statements made by or on behalf of you, Birth Mother, Biological Father, the Plaintiff Child(ren) or any Other Plaintiff relating to this litigation.
[Document(s) produced/No such document(s) exist(s)]

9. Copies of any Individualized Education Program, 504 plan, and documentation of any special educational accommodations or modifications, identified by you in Section IV.E, above.
[Document(s) produced/No such document(s) exist(s)/No such document(s) in my possession]

C. Authorizations

1. **Health Care Authorization:** For each health care provider identified in the responses above, please provide a completed and signed (but undated) Health Care Authorization in the form attached as Exhibit A.

2. **Psychiatric/Psychotherapy Notes Authorization:** For each psychologist, psychiatrist or psychotherapist identified in the responses above, please provide a completed and signed (but undated) Psychiatry/Psychotherapy Authorization in the form attached as Exhibit B.

3. **Education Authorization:** For each school identified in Section IV.E.1, above, please provide a completed and signed (but undated) School/Education Authorization in the form attached as Exhibit C.

4. **Medicare:** Please provided a completed and signed (but undated) Medicare Authorization in the form attached as Exhibit D.

5. **Social Security Authorization:** To the extent any Plaintiff has in the past or currently receives Social Security benefits as a result of or relating to the injuries alleged in this case, please provided a completed and signed (but undated) Social Security authorization in the form attached as Exhibit E.

VI. VERIFICATION

Pursuant to 28 U.S.C. § 1746, I declare that all of the information provided in connection with this Plaintiff Fact Sheet is true and correct to the best of my knowledge, information, and belief, that I have supplied or will supply all documents requested in Part V of the Plaintiff Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied or will supply the Authorizations attached to this declaration.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on ___/___/_____.

Name _____
(please print)

_____
Signature

PFS EXHIBIT “A”

HIPAA COMPLIANT AUTHORIZATION FORM TO DISCLOSE HEALTH INFORMATION
(Pursuant to 45 C.F.R. 164.508)

To: _____

Patient Name:_____**SSN:**_____**DOB:**_____

I, _____, hereby authorize you to release and furnish copies of the following information to:

_____Attorneys for Defendant(s) and/or its authorized representatives, including but not limited to _____.

This form authorizes the physicians, psychiatrists, psychologists, dentists, nurses, chiropractors, therapists, hospitals, pharmacies, clinics, nutritionists, dieticians, physical therapists, laboratories, weight loss centers, homeopaths, dispensaries, home health care providers or any other medical facility or health care provider, school or state, federal or local governmental unit (such as the Social Security Administration) to release any and all medical records, reports, x-rays, photographs, notes, bills, payment schedules, prescriptions or any other results of investigation, diagnosis, treatment or prognosis whether in paper or electronic form. This authorization shall extend to any medical condition, past or present.

- All records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, x-rays, diagnostic records, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records created or received by you or other physicians or staff, as well as all autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, diagnostic reports, genetic scans.
- All radiology films, ultrasounds, genetic material, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, and diagnostic material.
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- All billing records including all statements, itemized bills, and insurance records.

1. This authorization is being forwarded by, or on behalf of, my attorneys or attorneys for the defendants. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition, unless you receive and additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on my medical or physical condition at a deposition or trial.

2. I understand that the information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire three (3) years from the date of execution.

4. I understand that authorizing the disclosure of this health information is voluntary. I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign this document. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is <u>not</u> required. CFR 164.508. A copy of this authorization may be used in place of an original.

_____ _____

Date Signature

If not signed by Patient, complete below:

Name: _____ Describe authority: _____

PFS EXHIBIT “B”

PSYCHOTHERAPY NOTES AUTHORIZATION

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

ACKNOWLEDGEMENT: I understand and acknowledge that this Authorization is necessary to comply with state and federal laws pertaining to the use and disclosure of protected health/medical information ("PHI") about the Patient identified below, and that failure to provide all requested information may prevent a health care provider from acting on this Authorization.

Name of Patient: _____ DOB: _____

1. **PERSONS AUTHORIZED TO DISCLOSE PHI.** I authorize the following to disclose psychotherapy notes (defined below) pertaining to the Patient identified above as described in Section 2:
   _____
   _____

PSYCHOTHERAPY NOTES DEFINITION: Notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. *Psychotherapy notes* excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. (45 CFR § 164.501)

2. **DESCRIPTION OF INFORMATION.** This Authorization permits the use and disclosure of the information about the Patient identified above, dated _____ to present or created within that timeframe, contained in the following records:

☒ All psychotherapy notes pertaining to Patient identified above.

This Authorization also permits _____ to communicate regarding the information identified above for the purposes described in Section 4, including giving information in writing, by phone, and/or at meetings, or engaging in other related written and verbal communications in this matter.

3. **AUTHORIZED USERS AND RECIPIENTS.** I hereby authorize the following persons and classes of persons to receive and use the health information described in Section 2 above: _____ _____ and its representatives, employees, and agents including but not limited to _ _____. This document also authorizes the further disclosure and use of any information covered herein between and among any persons involved in the evaluation or adjudication of claims in this matter as described in Section 4.

4. **PURPOSE.** I hereby authorize the information checked in Section 2 above to be used and disclosed for the following purposes:

☒ Evaluation and adjudication of claims in *In Re Acetaminophen – ASD/ADHD Products Liability Litigation*, and/or any administrative or judicial proceedings involving the claims alleged in that action and/or any other claims arising from the facts alleged in that action; and/or any settlement conference or mediation proceeding involving the claims alleged in that action and/or any other claims arising from the facts alleged in that action; and/or any dispositive motions filed in that action; and/or any other adjudication of claims in that action, including at trial.

5. **RIGHT OF REVOCATION.** I understand that I have the right to revoke this Authorization at any time, provided that my revocation is in writing. The revocation should be addressed to _____ _____.

6. **LIMITS TO REVOCATION.** I understand that my revocation will be effective upon its receipt by the person(s) I authorized in Section 1, but would not be effective to the extent that such persons have acted in accordance with this Authorization and in reliance thereon. With respect to the person(s) I authorized to receive and use health information described in Section 3, if a patient (or personal representative) requested this Authorization, a revocation will be effective only when I communicate my revocation directly to them.

7. **REDISCLOSURE.** I understand that if a recipient of my information in Section 3 above is not a healthcare provider, a health plan or health care clearing house, or not an entity required to comply with federal or state health privacy regulations, the requested health information may be further disclosed by such recipient and that information may no longer be protected by state and federal laws. If this Authorization includes the disclosure of substance abuse information, the recipient may be prohibited from disclosing the substance abuse information under federal substance abuse confidentiality requirements.

8. **RIGHT TO REFUSE TO SIGN.** I understand I do not have to sign this Authorization, and my failure to sign this authorization will not affect the Patient's ability to obtain health care treatment, payment, enrollment, or eligibility for benefits.

9. **DURATION.** This Authorization will expire at the end of three (3) years from the date below.

   Upon expiration, written information received per this Authorization will be returned or destroyed.

10. **COPY OF AUTHORIZATION.** I have the right to receive a copy of this Authorization.

Signature of Patient *(or personal representative, if applicable)*	Date
Print name of personal representative (*if applicable*) (*Legal representative, parent, guardian, spouse, financially responsible party*)	Relationship to Patient
Address	Date of Birth

ATTENTION RECIPIENT: ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSE OF THIS DISCLOSURE

PFS EXHIBIT “C”

Authorization to Use or Disclose Information

I hereby authorize the disclosure and use of the information described below, which may include educational records and individually identifiable health information that is ordinarily protected from disclosure and use by federal and state law. I understand this authorization is voluntary. I understand that if the organization or persons authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient/Student Name:
Date of Birth:
Address:

Persons/organizations providing the information:

Persons/organizations receiving the information:

You are authorized and directed to provide copies of all records relating to the above former or current student, whether electronic or otherwise, including, but not limited to:

1. All correspondence regarding student including: letters, emails, video, recordings, and facsimiles. This shall include internal correspondence (*i.e.*, emails between representatives of the responding party) as well as correspondence sent to or received from student, his/her parents, or any medical, educational, or behavioral provider.

2. All medical records related to student, including: reports; results of testing, assessment, evaluation, and/or examination; records of hospitalization or consultation; x-rays, photographs, EKGs and/or labs; psychiatric, psychological, counseling, or other mental health records of any kind; notes, histories, or summaries; records of medications taken, administered, or prescribed; treatment plans; admission and discharge records; any documents containing diagnoses; and any documents containing conclusions or recommendations.

3. All educational records related to student including: academic reports; results of testing, assessment, evaluation, and/or examination; records showing present levels of performance; records showing goals and objectives; records showing progress and/or how it is monitored; records describing the curriculum and/or methodology being used; report cards; schedules; notes or summaries; educational plans of any kind; behavior plans; individualized education program (IEP), tutoring and/or special classes recommended, participation in extra-curricular activities, any documents containing determinations regarding the existence, nature, or severity or a disability; and any documents containing conclusions or recommendations.

4. All records concerning all therapies related to student, including: behavioral, physical, speech, language, occupational, audial and vision therapy.

5. All financial records regarding student, including: invoices, bills, statements, notices, loan documents, and insurance documents.

6. All contracts (*i.e.*, tuition agreements, loan agreements, agreements with private providers) regarding student.

Reason for use or disclosure of information:

Pending litigation

I understand that the student will not be denied health care or health plan coverage, as the case may be, if I do not sign this form.

I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility and agree to the release of my medical of billing records containing the sensitive information listed.

I understand that this authorization will expire three (3) years after the date below.

I understand that I may revoke this authorization at any time by notifying the person or organization providing the information in writing, but if I do, such revocation will not affect any actions taken before the revocation is received.

Patient/Student's Legal Guardian **Date**
(Please print and sign)

PFS EXHIBIT “D”

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0930
Expires: 11/30/2025

1-800-MEDICARE AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

Use this form if you want 1-800-MEDICARE to give your personal health information to someone other than you.

1. Print Name (First, Middle, Last, Suffix) of the person with Medicare

Medicare Identification Number (if issued), exactly as shown on the Medicare Card	**Date of Birth** (mm/dd/yyyy)

2. Medicare will only disclose the personal health information you want disclosed.

2A: Check only one box below to tell Medicare the specific personal health information you want disclosed:

☐ Limited Information (go to question 2b)

☒ Any Information (go to question 3)

2B: Complete only if you selected "limited information". Check all that apply:

☐ Information about your Medicare eligibility

☐ Information about your Medicare claims

☐ Information about plan enrollment (e.g. drug or MA Plan)

☐ Information about premium payments

☐ Other Specific Information (please write below; for example, payment information)

_____

_____

_____

2C: NY Residents Only, this section must be completed.
Please select one of the following options: (Please check only one box.)

☐ Include all information. This includes information about alcohol and drug abuse, mental health treatment, and HIV.

☐ Exclude information about alcohol and drug abuse, mental health treatment, and HIV.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0930
Expires: 11/30/2025

3. Check only one box below indicating how long Medicare can use this authorization to disclose your personal health information (subject to applicable law—for example, your State may limit how long Medicare may give out your personal health information):

☐ Disclose my personal health information indefinitely

☒ Disclose my personal health information for a specified period only

beginning: _____ (mm/dd/yyyy) and ending: _____ (mm/dd/yyyy)

4. Fill in the reason for the disclosure (you may write "at my request"):

Pending litigation

5. Fill in the name and address of the person or organization to whom you want Medicare to disclose your personal health information. Please provide the specific name of the person for any organization you list below. If you would like to authorize any additional individuals or organizations, please add those to the back of this form.

Name _____

Address _____

Name _____

Address _____

Note: You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. To revoke authorization, send a written request to the address noted below. Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for the health services you receive.

Form Approved
OMB No. 0938-0930
Expires: 11/30/2025

6.

I authorize 1-800-MEDICARE to disclose my personal health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law.

Signature	Telephone Number	Date (mm/dd/yyyy)

Print the address of the person with Medicare (Street Address, City, State and ZIP)

_____

_____

☐ Check here if you are signing as a personal representative and complete below.

Please attach the appropriate documentation (for example, Power of Attorney. This only applies if someone other than the person with Medicare signed above.

Print the Personal Representative's Address (Street Address, City, State, and ZIP)

_____

_____

Telephone Number Personal Representative: _____

Personal Representative's Relationship to the Beneficiary: _____

Form Approved
OMB No. 0938-0930
Expires: 11/30/2025

7. Send the completed, signed authorization to:

Medicare CCO, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

Note: You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. If you would like to revoke authorization, send a written request to the address noted above.

Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for the health services you receive.

PFS EXHIBIT “E”

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3. To comply with Federal laws requiring the disclosure of the information from our records; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at** www.socialsecurity.gov**. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

*My Full Name	*My Date of Birth (MM/DD/YYYY)	*My Social Security Number

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:** ***ADDRESS OF PERSON OR ORGANIZATION:**

***I want this information released because:**
We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**
Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☒ Verification of Social Security Number
2. ☒ Current monthly Social Security benefit amount
3. ☒ Current monthly Supplemental Security Income payment amount
4. ☒ My benefit or payment amounts from date _____ to date _____
5. ☒ My Medicare entitlement from date _____ to date _____
6. ☒ Medical records from my claims folder(s) from date _____ to date _____
   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☒ Complete medical records from my claims folder(s)
8. ☒ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

Applications, questionnaires, determinations, awards, denials, appeals, doctor reports, and consultative exams

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1. Signature of witness	2. Signature of witness
Address(Number and street, City, State, and Zip Code)	Address(Number and street, City, State, and Zip Code)